STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	**7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 156	Continued From page 1 The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to	F 156		

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F 156	Continued From page 2 receive refunds for previous payments covered by such benefits. This Requirement is not met as evidenced by: The facility reported a census of 33 residents. Three residents were reviewed for medicare notice of non-coverage. Based on record review and interview, the facility failed to inform the residents of services ending for 3 of 3 (#51, #59, and #7) records reviewed. Findings included: - Review of Medicare A notice of non-coverage for resident #51 revealed the notice lacked a patient number and failed to inform the resident/representative, of the type of Medicare services that were ending. Interview on 8/13/13 at 2:45 P.M. staff HH confirmed the form did not identify the resident's identification number nor the type of medicare services that were discontinued. The facility failed to provide a complete medicare notice of non-coverage to include the type of medicare services ending and the resident's identification number. - Review of Medicare A notice of non-coverage for resident #59 revealed the notice lacked a patient number and failed to inform the resident/representative, of the type of Medicare services that were ending. Interview on 8/13/13 at 2:45 P.M. staff HH confirmed the form did not identify the resident's	F 156		

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F 156	Continued From page 3 identification number nor the type of medicare services that were discontinued. The facility failed to provide a complete medicare notice of non-coverage to include the type of medicare services ending and the resident's identification number. - Review of Medicare A notice of non-coverage for resident #7 revealed the notice lacked a patient number and failed to inform the resident/representative, of the type of Medicare services that were ending. Interview on 8/13/13 at 2:45 P.M. staff HH confirmed the form did not identify the resident's identification number nor the type of medicare services that were discontinued. The facility failed to provide a complete medicare notice of non-coverage to include the type of medicare services ending and the resident's identification number.	F 156		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This Requirement is not met as evidenced by:	F 167		

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F 167	Continued From page 4 The facility identified a census of 33 residents. The sample included 18 residents. Based on observation and interview the facility failed to provide the most recent survey results of the federal and state survey with the plan of correction in a readily accessible area for residents and visitors on 1 of 4 days onsite during the survey. Findings included: - On 8-8-13 at 9:29 A.M. a sign at the nurses' station documented the latest survey results were available to review. At that time licensed nurse N stated the survey results were not at the nurses' station, they were located in the administration office on the assisted living side of the facility, and you had to ask to review the results. On 8-14-13 at approximately 3:30 P.M. resident #26 stated he/she was not aware of what the survey results were or where they were located. On 8-14-13 at approximately 6:30 P.M. administrative staff A stated the facility did not have a policy for survey results and followed regulatory guidelines. The facility failed to prominently display the federal and state survey results for residents and visitors.	F 167		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that	F 242		

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F 242	Continued From page 5 are significant to the resident. This Requirement is not met as evidenced by: The facility identified a census of 33 residents. The sample included 18 residents of which 3 were reviewed for choices. Based on observation, interview, and record review the facility failed to provide choices and preferences for one resident regarding bedtime, (#48) and bathing choices for one resident (#85). Findings included: - Resident #48's admission Minimum Data Set 3.0 Assessment (MDS) dated 7-6-13 documented the resident's Brief Interview for Mental Status Score of 12 which indicated the resident had moderately impaired cognition. The resident required extensive assistance with activities of daily living (ADLs) for bed mobility, transfers, locomotion on and off unit, dressing, toilet use, and personal hygiene. The MDS documented it was very important for the resident to choose his/her own bedtime. Review of the 8-13-13 care plan lacked documentation of the resident's choices and preferences. Observation on 8-12-13 at 4:35 P.M. revealed the resident sat in his/her wheelchair in his/her room with the TV on. On 8-8-13 at 11:27 A.M. during an interview with the resident, he/she stated he/she liked to go to bed around 11:00 P.M. or around midnight, but staff informed him/her, he/she had to go to bed by 10:00 P.M.	F 242		

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On 8-13-13 at 4:08 P.M. direct care staff U stated he/she asked the resident when he/she wanted to go to bed during the evening and was not aware the resident wanted to stay up later.

On 8-14-13 at 7:04 A.M. licensed staff BB stated the resident was in bed when he/she came on duty at 10:00 P.M.

On 8-14-13 at 11:41 A.M. social services staff HH acknowledged the resident's preferences and choices were not documented on the plan of care.

On 8-14-13 at 1:17 P.M. licensed nurse J stated the certified nursing assistants (CNAs) were made aware of the residents' choices and preferences from the care plan and the nurses updated the CNAs with any changes for the residents.

The facility failed to provide the resident his/her choice of bedtime.

- The Minimum Data Set (MDS) 3.0 an admission assessment dated 7/25/13 listed resident #85 required total dependence of one staff for bathing.

The Care Area Assessment (CAA) for Activities of Daily Living (ADL) dated 7/25/13 listed the resident required help with his/her ADL's. He/she had a recent CVA (cerebral vascular accident, an event that affects mental and physical abilities), and a decline in his/her functional mobility. He/she also had impaired cognition (poor mental function) which could affect his/her ability with activities of daily living performance.

The care plan dated 7/18/13 for bathing listed the

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resident took a shower with the preferred day of Wednesday, after lunch, before dinner, or before bed. He/she required extensive to total assistance for bathing with 1 to 2 person physical assistance.

Observation on 8/12/13 at 1:30 P.M. the resident laid in bed sleeping. At 4:30 P.M. the resident was in his/her room in the wheelchair with the speech therapist present.

On 8/13/13 at 7:10 A.M. the resident laid in bed asleep with the bed in the low position.

The clinical record lacked documentation of when or the type of bath the resident received.

Interview on 8/12/13 at approximately 10:15 A.M. the resident was unaware of what days he/she received baths. The resident stated I receive a bath sometimes in the morning sometimes in the night, and sometimes not at all. I would like at least 2 baths a week.

Interview on 8/12/13 at approximately 3:30 P.M. direct care staff O stated the resident's bath days were Monday day shift and Thursday 2 to 10 shift. He/she gave the resident a bed bath on Thursdays on the days direct care staff O worked.

Interview on 8/13/13 at 9:30 A.M. direct care staff CC stated I gave the resident
a bed bath on Saturdays in the morning when I am here. The resident cannot sit up straight and he/she was not safe in the shower. Staff only fill out the bath sheet if there was a new skin issue. Direct care staff CC stated the residents' bath days were Monday evening and Saturday mornings. There was no place to document that a bath was given to the resident, we only document

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F 242	Continued From page 8 that we took care of the resident for the shift. Review of the certified nurse assistant sample flow sheet provided by the facility revealed baths for residents were scheduled by rooms, and per this sheet, baths for this resident were listed as Monday evenings and Saturday mornings. Interview on 8/14/13 at 5:25 P.M. with administrative nursing staff D revealed he/she was not aware the resident received bed baths, and believed he/she saw the resident get a shower 2 times. Administrative nursing staff D confirmed there was no documentation of showers the resident received, and the care plan should address 2 showers a week on a consistent basis. The facility failed to provide the resident a choice of bathing on a consistent basis.	F 242		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279		

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F 279	Continued From page 9	F 279		

due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This Requirement is not met as evidenced by:
The facility identified a census of 33 residents. The sample included 18 residents. Based on observation, interview, and record review, the facility failed to develop an individualized care plan for bathing for 1 resident of the sample (#85).

Findings included:

- The admission Minimum Data Set 3.0 dated 7/25/13 identified resident #85 required total dependence of one staff for bathing.

The Care Area Assessment (CAA) for activities of daily living dated 7/25/13 listed the resident required help with his/her activities of daily living (ADLs). He/she had a recent CVA (cerebral vascular accident, an event that affects mental and physical abilities), and a decline in his/her functional mobility. He/she also had impaired cognition, (poor mental function) which could affect his/her ability with (ADL) performance.

The care plan dated 7/18/13 for bathing listed the resident took a shower with the preferred day of Wednesday, after lunch, before dinner, or before bed. He/she required extensive, total assistance for bathing with 1 to 2 person physical assistance.

Observation on 8/12/13 at 1:30 P.M. the resident laid in bed sleeping. At 4:30 P.M. the resident was in his/her room in the wheelchair with the speech therapist present.

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F 279	Continued From page 10 On 8/13/13 at 7:10 A.M. the resident laid in bed asleep, with the bed in the low position. The clinical record lacked documentation of when or the type of baths the resident received. Interview on 8/12/13 at approximately 10:15 A.M. revealed the resident was unaware of what days he/she received baths, the resident stated I received a bath sometimes in the morning, sometimes in the night, sometimes not at all. I would like at least 2 baths a week. Interview on 8/12/13 at approximately 3:30 P.M. direct care staff O stated the resident's bath days were Monday day shift, and Thursdays 2-10 shift. I gave the resident a bed bath on the Thursdays I work. Interview on 8/14/13 at 9:30 A.M. with direct care staff CC stated I gave the resident a bed bath on Saturdays in the morning when I work. He/she cannot sit up straight and he/she was not safe in the shower. Direct care staff CC stated the residents bath days were Monday evenings and Saturday mornings. Review of the sample certified nurse assistant (CNA) flow sheet provided by the facility revealed baths for residents were scheduled by rooms, and per this sheet, baths for this resident were listed as Monday evenings and Saturday mornings. Interview on 8/14/13 at 5:25 P.M. with administrative nursing staff D revealed the care plan should address the 2 showers a week. The facility failed to develop an accurate individualized care plan for this resident for	F 279		

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F 279	Continued From page 11 bathing.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by: The facility identified a census of 33 residents. The sample included 18 residents. Based on observation, interview, and record review the facility failed to review and revise the care plan for 4 of 18 residents (#31, #48, #5, #70) to include changes in care and failed to invite resident #48 to his/her care planning meeting. Findings included: - Resident #31's quarterly Minimum Data Set 3.0 Assessment (MDS) dated 6-19-13 documented the resident's Brief Interview for Mental Status	F 280		

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F 280	Continued From page 12 Score (BIMS) of 12, which indicated the resident with moderately impaired cognition. The resident required extensive assistance of staff with activities of daily living (ADLs) for ambulation, limited assistance with transfers, dressing, and toilet use. The resident required supervision of staff for personal hygiene, eating, and bed mobility. The MDS documented the resident displayed verbal behaviors 1 to 3 days of the seven day assessment period and rejected care 1 to 3 days of seven day assessment period. The Psychotropic Care Area Assessment (CAA) dated 9-28-12 documented the resident received medications prescribed by his/her physician and psychiatrist, had periods of anxiety with inappropriate verbalization, panic attacks, and swore at staff and other residents. The 8-9-13 Care Plan documented the resident received anti-psychotic medication and increased the residents Buspar (an anti-depressant medication) dosage. The resident was impulsive, became angry, anxious and was verbally abusive at times. The resident required cueing, reassurance and required reality orientation at times. The care plan directed staff to speak to the resident in a calm, quiet manner as the resident's behavior escalated easily. The care plan documented the resident was obsessed with his/her inhalers and oxygen. The care plan directed staff to remind the resident to call for assistance if he/she became anxious or had shortness of air. Review of the resident's medications revealed he/she received Advair Diskus (a medication used to treat lung disorders that caused shortness of air) inhaler every 12 hours for shortness of air, alprazolam (an anti-anxiety	F 280		

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medication) three times daily and as needed for anxiety, Seroquel (an anti-psychotic medication) three times daily, and Proair (a medication used to treat lung disorders that caused shortness of air) inhaler as needed for shortness of air.

The 7-12-13 Psychiatric exam documented the resident with some improvement of his/her behaviors.

The 5-29-13 interdisciplinary note (ID) with no time written, documented the resident came to the nurses' station multiple times during the day and requested his/her inhaler and the resident had memory problems. Staff informed the resident's family if the resident continued to have the psychotic behaviors, he/she would be referred the a gerontology (elderly) psychiatric unit.

The 5-31-13 ID note with no time written, documented the resident's family requested staff to inform them when the resident had temper tantrums. The physician prescribed Seroquel for the resident.

An undated and untimed ID note entered between 7-27-13 and 7-31-13 documented the resident continued to receive Buspar and Seroquel, became disruptive at times, screamed, yelled and asked for his/her inhalers. The resident was hateful and inappropriate toward staff.

On 8-7-13 with no time written, the ID note documented staff notified the resident's family of the resident's belligerent and disruptive behaviors. The resident demanded his/her inhalers and breathing treatments. Staff gave the resident the prescribed treatments but the resident did not get relief. The ID note

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documented the resident had anxiety and his/her verbal aggression escalated.

On 8-9-13 at 5:35 P.M. the ID note documented staff obtained an order to increase the resident's Buspar dosage for his/her increased behaviors.

Observation on 8-12-13 at 4:34 P.M. revealed the resident sat in his/her wheelchair in activity room with other residents and staff and no behaviors exhibited.

Observation on 8-13-13 at 8:30 A.M. revealed the resident in the dining room for the breakfast meal with other residents and staff and no behaviors exhibited.

On 8-13-13 at 4:08 P.M. direct care staff U stated the resident had behaviors when he/she had difficulty with breathing and he/she would yell and curse staff. Direct care staff U stated when the resident had behaviors, staff left and came back later.

On 8-14-13 at 10:14 A.M. direct care staff Q stated the resident did not like 2 people entering his/her room, had a lot of behaviors and would apologize after displaying behaviors. Direct care staff Q stated the resident became anxious because he/she thought something was wrong. He/she stated the resident screamed throughout his/her showers.

On 8-14-13 at 11:41 A.M. social services staff HH stated staff redirected the resident, spoke to the resident in a calm manner, provided one to one interaction, and redirected the resident. He/she acknowledged the care plan lacked the specific behaviors and interventions for the behaviors displayed.

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F 280	Continued From page 15 On 8-14-13 at 1:17 P.M. licensed staff J stated he/she was not certain what triggered the resident's behaviors and when the resident had a panic attack, the resident felt staff did not respond fast enough. He/she stated staff tried to re-direct the resident, did not argue with the resident and gave the resident what he/she wanted without conversation because that also upset the resident. The facility failed to review and revise the care plan that addressed the resident's specific behaviors and specific interventions for the behaviors. - Resident #48's admission Minimum Data Set 3.0 Assessment (MDS) dated 7-6-13 documented the resident's Brief Interview for Mental Status Score of 12 which indicated the resident had moderately impaired cognition. The resident required extensive assistance of staff with activities of daily living (ADLs) for bed mobility, transfers, locomotion on and off unit, dressing, toilet use, and personal hygiene. The 8-11-13 care plan documented the resident was on a fluid restriction. The care plan lacked information regarding how much fluid the resident was allowed and lacked interventions how staff distributed fluids throughout the day for the resident. Review of the care plan lacked evidence staff invited the resident and/or Durable Power of Attorney (DPOA) to his/her care plan meeting. On 7-31-13 the resident's cardiologist ordered fluid restriction of 2 liters (64 ounces) in a 24 hour period.	F 280		

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F 280	Continued From page 16 Record review revealed the resident admitted to the facility on 6-29-13. The record lacked evidence staff monitored the resident's fluid restriction per the physician's order on 7-31-13. Review of the residents record lacked evidence staff invited the resident to attend his/her comprehensive care plan meeting. Observation on 8-13-13 at 8:32 A.M. revealed the resident in the dining room and staff served the resident a cup of coffee, a glass of milk, juice, and water. On 8-13-13 at 1:30 P.M. the resident did not recall staff inviting him/her to a care plan meeting and stated he/she directed his/her own care. On 8-14-13 at 9:23 A.M. social services staff HH acknowledged the resident did not have a DPOA and stated the resident was in and out of the hospital several times and staff did not schedule a care plan meeting for him/her. On 8-14-13 at 11:41 A.M. social services staff HH acknowledged the care plan lacked interventions for monitoring the resident's fluid restriction. The facility failed to review and revise the care plan to include distribution of fluid related to the resident's fluid restriction and failed to invite the resident to attend his/her care plan meeting. - The quarterly Minimum Data Set (MDS) 3.0 dated 6/19/13 for resident #5 revealed a Brief Interview for Mental Status score of 5 (severe cognitive impairment). The resident required supervision with set up help with eating.	F 280		

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The revised care plan dated 6/17/13 for dining, nutrition, and oral care revealed the resident received a regular diet and was on the special nutrition program (SNP). Nursing staff would weigh the resident weekly and notify the physician and registered dietitian of significant weight loss or gain. The resident liked coffee at meals, received a supplement daily with noon meal, and was offered a snack at night. Nursing staff would encourage the resident to finish her/his meals and fluids. The resident usually refused offers of snacks. The resident could eat what she/he wished to and as much as she/he wished. The resident was at risk for weight loss due to a diagnosis of failure to thrive (inappropriate weight loss). The resident would receive super cereal with breakfast and cranberry juice twice a day when available.

The care plan lacked documentation from observation and interview the resident required set up assist with meals.

Observation on 8/8/13 at 12:53 P.M. revealed a visitor of another resident assisted in cutting up the resident's food. A different visitor shortly after sat down beside the resident and assisted her/him with eating. A nursing staff member sat behind the resident assisting another resident.

Observation on 8/14/13 at 12:25 P.M. revealed the resident's visitor had cut up a beef patty and assisted the resident in eating.

Interview on 8/8/13 at 12:40 P.M. with the resident's durable power of attorney (DPOA) stated she/he came daily at noon to ensure the resident ate and received assistance with her/his meal. She/he did not feel there was enough staff in the dining room to assist residents.

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F 280	Continued From page 18 Interview on 8/13/13 at 4:06 P.M. with direct care staff O stated the resident required assistance with cutting up food and assistance with meals. Interview on 8/14/13 at 1:54 P.M. with direct care staff R stated the resident's DPOA assisted the resident with noon meals. The resident required assistance with cutting up meals and required constant cueing. Interview on 8/14/13 at 12:19 P.M. with licensed nursing staff L stated the resident had days when she/he required staff assistance with meals. The DPOA came daily to ensure she/he ate. Nursing staff updated the care plans to reflect a resident's current care. Interview on 8/14/13 at 2:51 P.M. with administrative nursing staff D stated the nursing staff updated the care plans to reflect a resident's activity of daily living needs. The facility failed to revise/update the resident's care plan for this resident who required assistance with meals. - The August 2013 Physician's Order Sheet for resident #70 documented a diagnosis of dementia with psychosis (a progressive mental disorder characterized by failing memory and confusion with any major mental disorder characterized by a gross impairment in reality testing). The Significant Change Minimum Data Set 3.0 dated 5/1/13 revealed a Brief Interview for Mental	F 280		

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F 280	Continued From page 19 Status score of 1 (less than 7 indicated severely impaired cognition). Review of this resident's care plan on 8/13/13 at 2:00 P.M. dated 4/24/13 for nutrition documented this resident needed a plate guard at all meals. The dietician note dated 8/13/13 recommended to discontinue the plate guard as it was not further warranted. Interview on 8/14/13 at 9:30 A.M. licensed nursing staff J stated the nurses were responsible for updating the information on the care plans. Interview on 8/14/13 at 3:00 P.M. with administrative nursing staff D stated the nurses were responsible for updating the care plans as needed. The facility policy "Skilled Nursing Individualized Care & Service Plan Standards of Performance" failed to address the process for updating the care plans. The facility failed to revise the care plan to reflect this resident's assistive devices.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This Requirement is not met as evidenced by:	F 309		

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The facility reported a census of 33 residents. The sample included 18 residents. Based on observation, record review, and interviews, the facility failed to investigate bruising of unknown origins for 1 (#17) resident, and failed to follow the physician's orders for fluid restriction for 1 (#48) resident in the sample.

Findings included:

- The 60-day Minimum Data Set (MDS) 3.0 dated 6/19/13 for resident #17 revealed a Brief Interview for Mental Status score of 4 (severe cognitive impairment). The resident required extensive assistance of one person for bed mobility, transfers, walking in her/his room/corridor, locomotion on/off the unit, dressing, toilet use, personal hygiene, and bathing. The resident was not steady and required stabilization with staff assistance when moving from seated to a standing position, walking, turning around, moving on and off the toilet, and surface-to surface transfer. The resident did not have impairment to the upper/lower extremities, and used a walker and wheelchair for mobility.

The revised care plan dated 6/9/13 for skin revealed nursing staff would perform a weekly skin assessment and report to the physician any skin issues. The certified nursing aide (CNA) would observe and report skin issues to the nurse.

The Nursing Notes dated 8/3/13 at 10:20 P.M. revealed the resident had a large bruise (5 inches by (x) 6 inches) on the right lower outer arm. The resident's family member stated she/he noted the bruise and she/he and the resident did not know how the resident received the bruise. The

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F 309	Continued From page 21 resident stated the bruised area did not hurt. Observation on 8/8/13 at 12:50 P.M. revealed the resident had a large bruise on the right wrist. Observation on 8/12/13 at 2:15 P.M. revealed the resident had a large bruise on the left forearm and right hand. Record review on 8/14/13 at 10:00 A.M. lacked documentation of an investigation for bruising of unknown origins. Interview on 8/12/13 at 2:17 P.M. with the resident stated she/he was not sure how she/he obtained the bruises. Interview on 8/13/13 at 4:20 P.M. with direct care staff Q stated she/he did know how the resident obtained the bruises. She/he would notify the nurse if she/he noted bruising on a resident. Interview on 8/14/13 at 9:16 A.M. with licensed nursing staff J stated nursing staff documented bruising in the nurses' notes and staff would initiate an investigation form. Interview on 8/14/13 at 9:23 A.M. with administrative nursing staff D stated she/he was unable to find any documentation for investigation of the resident's bruising. Nursing staff should report and investigate the resident's bruises. Interview on 8/14/13 at 12:19 P.M. with licensed nursing staff L stated nursing staff would initiate an investigation form for bruises of unknown origins. Interview on 8/14/13 at 10:00 A.M. with administrative staff A stated she/he could not find	F 309		

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F 309	Continued From page 22 any investigation documentation for the resident's bruising. The facility failed to investigate bruising of unknown origins for this cognitively impaired resident. - Resident #48's admission Minimum Data Set 3.0 Assessment (MDS) dated 7-6-13 documented the resident's Brief Interview for Mental Status Score of 12 which indicated the resident had moderately impaired cognition. The resident required extensive assistance of staff with activities of daily living (ADLs) for bed mobility, transfers, locomotion on and off unit, dressing, toilet use, and personal hygiene. The 8-11-13 care plan documented the resident was on a fluid restriction. The care plan lacked information regarding how much fluid the resident was allowed and lacked interventions how staff distributed fluids throughout the day for the resident. On 7-31-13 the resident's cardiologist ordered fluid restriction of 2 liters (64 ounces) in a 24 hour period and directed staff to weigh the resident in the morning after he/she went to the bathroom and before he/she ate breakfast. On 7-31-13 at 2:00 P.M. the interdisciplinary (ID) note documented the resident returned to the facility from a physician's appointment. The physician ordered daily weights for the resident and notify him/her if the resident gained 3-5 pounds in 3-5 days. The physician ordered fluid restriction of no more than 2 liters (64 ounces) in a 24 hour time period, and elevate the resident's	F 309		

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F 309	Continued From page 23 legs as much as possible. The 8-4-13 Medication Administration Record (MAR) documented the resident received Lasix (a medication that excreted fluid from the body) 60 milligrams (mg) daily and if the resident gained 2 or more pounds of fluid in 24 hours, staff gave the resident and extra 20 mg of Lasix. The resident's record lacked evidence staff monitored the resident's fluid restriction. The resident's record documented the resident went to the hospital on 8-6-13 and returned to the facility on 8-7-13. Review of the MAR recorded the resident's weight the following days for August 2013: 8-4- 194 pounds (lbs) 8-5 -200 lbs 8-6 - in hospital 8-7 - in hospital 8-8 - no weight documented 8-9 - no weight documented 8-10 - 208 lbs 8-11 - 209.4 lbs 8-12 - 205.6 lbs 8-13 - no weight documented 8-14 - no weight documented On 8-2-13 with no time written, the ID note documented the resident saw the physician and was on a 2 liter fluid restriction and had weekly visits to the wound clinic for aggressive treatment of the wounds on his/her feet. On 8-14-13 at approximately 1:50 P.M. social services staff HH acknowledged the resident's MAR lacked documentation of the resident's	F 309		

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weight on the above dates and asked direct care staff R if he/she had the resident's weights for 8-13 and 8-14-13. Direct care staff R pulled a paper from his/her pocket and stated the resident's weight on 8-13-13 was 218.2 lbs and 221.8 lbs on 8-14-13. Social Services staff HH recorded the weights on the resident's MAR at that time.

On 8-14-13 at approximately 2:00 P.M. review of the resident's record lacked evidence staff notified the physician they did not weigh the resident on 8-8 or 8-9-13 or provide medication treatment, re-weigh or notify the physician of the resident's increased weight gain for 8-13 or 8-14-13.

Observation on 8-13-13 at 8:32 A.M. revealed the resident in the dining room and staff served the resident a cup of coffee, a glass of milk, juice, and water.

On 8-14-13 at 12:15 P.M. licensed staff J and M were not aware the resident had a fluid restriction. After review of the resident's record licensed staff J acknowledged the physician's order for fluid restriction and stated they did not have a plan for monitoring the resident's fluid intake.

On 8-14-13 at 2:33 P.M. licensed staff L acknowledged the MAR lacked weights on August 8th and 9th and the 13th and 14th. He/she acknowledged the substantial weight increase on the 13th and 14th and staff should of re-weighed the resident. He/she acknowledged the resident did not receive additional Lasix for the increased weight. He/she stated the night shift certified nursing assistants (CNAs) weighed the resident each morning.

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F 309	Continued From page 25 The facility failed to monitor the resident's fluid restriction and failed to weigh the resident daily as ordered by the physician.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility identified a census of 33 residents. The sample included 18 residents. Based on observation, interview, and record review the facility failed to investigate 3 of 5 falls for 1 (#17) of 4 residents sampled for falls, and failed to lock the 2 doors of one of 3 prep kitchen in which a stream table contained 4 wells that contain hot water for 1 of 4 days of survey. Findings included: - Observation on 8/8/13 at 9:20 A.M. revealed dietary staff DD entered an unlocked prep kitchen on the long term care unit. The unattended prep kitchen revealed steam table wells uncovered and steam rising from the wells. The hot water was tempted by dietary staff DD which read 132.8 degrees Fahrenheit (F).The door to the adjoining dining room was unlocked and 4 residents were in the dining room. Interview on 8/8/13 at 9:30 A.M. with dietary staff DD stated the prep kitchen door was never	F 323		

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locked and the steam table was recently turned off.

On 8/8/13 at 9:40 A.M. the steam table wells were re-tempted with surveyor LL with two different thermometers which read 131.5 F and 131.1 F.

Interview on 8/8/13 at 9:45 A.M. dietary staff DD and administrative nursing staff D acknowledge the temperatures and the potential hazard to residents.

Interview on 8/8/13 at 10:15 A.M. administrative nursing staff D identified 7 independently cognitively impaired mobile residents on the long term care unit.

The facility failed to provide a safe and hazard free environment on the long term care unit with 7 cognitively impaired mobile residents.

- The signed Physician's Order Sheet (POS) dated 4/24/13 for resident #17 revealed a diagnosis of right femur fracture (broken right hip).

The 60-day Minimum Data Set (MDS) 3.0 dated 6/19/13 revealed a Brief Interview for Mental Status score of 4 (severe cognitively impaired). The resident required extensive assistance of one person for bed mobility, transfers, walking in her/his room/corridor, locomotion on/off the unit, dressing, toilet use, personal hygiene, and bathing. The resident was not steady and needed stabilization with staff assistance with moving from seated to standing position, walking, turning around, moving on and off the toilet, and surface-to surface transfer. The resident did not

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have impairment to her/his upper/lower extremities and used a walker, and wheelchair for mobility. The resident had one noninjury fall since admission/entry or reentry or prior assessment.

The Care Area Assessment dated 5/7/13 for Falls revealed the resident had a history of falls with injury and required extensive assistance with transfers, toileting, and activities of daily living. Non-skid footwear was worn while out of bed to prevent slips. Her/his wheelchair and bed had alarms in place to alert nursing staff and to remind the resident not to get up without assist. The resident's bed was kept in low position and a mat was placed beside her/his bed while in bed.

The revised care plan dated 6/24/13 for falls revealed a chair/bed alarm at all times to alert nursing staff, bed place in the lowest position with a bedside fall mat, repositioning when seated on the edge of a chair, physical and occupational therapy, nursing staff would provide assistance with all transfers until therapy stated she/he was safe on her/his own, required extensive assistance of 1 person, nursing staff would ensure the resident wore nonskid footwear while out of bed to prevent slips on floor, would toilet the resident upon rising, at bed time, before/after meals, and as needed, the pharmacy review was performed monthly and as needed, and keep frequently used items within resident reach.

The Skilled Nursing Health and Service Evaluation and Assessment dated 4/24/13 revealed the resident had a fall in the past 30 days, had a history of falls, used assistive devices, had unsteady gait, dementia/Alzheimer's (progressive mental deterioration characterized by confusion and memory failure), and unsafe transfers. Resident approaches consisted of

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bed/chair alarms and the bed in the lowest position with a bedside mat.

The Nursing Notes (NN) dated 4/28/13 and untimed revealed nursing staff witnessed the resident slide out of her/his wheelchair to the floor.

Record review 8/14/13 at 7:25 A.M. lacked documentation of a fall investigation.

The NN dated 5/12/13 at 11:30 P.M. revealed the resident was on found laying on the fall mat by the bed.

The Fall Investigation Checklist dated 5/11/13 revealed the resident had a history of falls. Safety interventions were in place at time of fall which consisted of a low bed and a fall mat. The resident was encouraged to call for assistance. The call light was within the resident reach.

The NN dated 5/31/13 at 2:01 A.M. revealed the certified nursing aide (CNA) responded to a bed alarm sounding and the resident was found crawling on the floor in her/his room near the floor mat. The bed was at the lowest position, floor mat was in place and the call light was within reach which the resident did not use.

Record review 8/14/13 at 7:25 A.M. lacked documentation of a fall investigation.

The NN dated 6/24/13 at 10:00 A.M. revealed the resident's alarm sounded from her/his room and staff found the resident on the fall mat on his/her knees. The resident attempted to crawl away from the bed.

Record review 8/14/13 at 7:25 A.M. lacked

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F 323	Continued From page 29 documentation of a fall investigation. The NN 7/24/13 at 11:30 P.M. a direct care staff member found the resident sitting on the floor on the fall mat. The bed alarm had sounded. The resident stated she/he tried to crawl to his/her wheelchair located at the foot of the bed. The Fall Investigation Checklist dated 7/28/13 revealed the resident had a history of falls, safety interventions were in place such as a bed/chair alarm, bed in low position with a fall mat. Fall intervention was to maintain resident within site at all times. Observation on 8/12/13 at 2:17 P.M. revealed the resident layed in a low positioned bed, a call light was within reach and a fall mat in place. Observation on 8/13/13 at 7:13 A.M. revealed the resident slept in a low positioned bed, a call light within reach, a fall mat on the floor by the bed, and a bed alarm attached to the resident. Observation on 8/13/13 at 9:12 A.M. revealed the resident sat in the TV room in a wheel chair with a chair alarm on. Interview on 8/14/13 at 2:07 P.M. with direct care staff W stated the charge nurse initiated the fall investigation forms with falls. Interview on 8/13/13 at 4:32 P.M. with licensed nursing staff H stated nursing staff initiated and completed a fall investigation form with falls. Interview on 8/14/13 at 9:16 A.M. with licensed nursing staff J stated nursing staff initiated a fall investigation form for witnessed or unwitnessed falls.	F 323		

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F 323	Continued From page 30 Interview on 8/14/13 at 9:24 A.M. with administrative nursing staff D stated she/he found only the fall investigation forms for the falls of 5/11/13 and 7/24/13. Nursing staff should immediately initiate fall investigation forms after a fall.. The facility failed to provide a Fall Investigation policy and procedure. The facility failed to assess and investigate fall interventions for this cognitively impaired mobile resident.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This Requirement is not met as evidenced by: The facility identified a census of 33 residents. The sample included 18 residents, of which 3 were reviewed for nutrition. Based on observation, record review and interview, the facility failed to prevent weight loss for one (#70) resident of the sample. Findings included:	F 325		

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F 325	Continued From page 31 - The August 2013 Physician's Order Sheet for resident #70 documented a diagnosis of dementia with psychosis (a progressive mental disorder characterized by failing memory and confusion with any major mental disorder characterized by a gross impairment in reality testing), pureed diet with spoon thick liquids, a magic cup (a nutritionally enhanced ice cream) twice a day, and hospice services for end stage dementia. The telephone ordered dated 4/24/13 revealed the resident was admitted to the long term care unit from the assisted living unit. The Significant Change Minimum Data Set 3.0 dated 5/1/13 revealed a Brief Interview for Mental Status score of 1 (less than 7 indicated severely impaired cognition), and the resident required limited assistance of one person with eating. The Care Area Assessment (CAA) dated 5/3/13 for cognition documented this resident needed staff to help with decisions daily for safety, and to anticipate this resident's needs as he/she only made his/her basic needs known at times. The CAA dated 5/3/13 for functional/rehabilitation potential did not trigger. The care plan for this resident dated 4/24/13 for nutrition documented this resident needed assistance with eating most of the meal and to put syrup/honey on food if resident did not act interested in food. On 5/30/13 the resident to receive two magic cups at lunch and dinner. An intervention was added on 6/12/13 to not put food in front of the resident until staff were ready to help the resident eat.	F 325		

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F 325	Continued From page 32 The 5/8/13 dietician progress note documented the resident received a pureed honey thick liquid diet with a magic cup two times a day. Review of 2013 weight logs documented: April - 92 pounds (lbs), May - 89 lbs June - 85 lbs July - 79 lbs - consisting of a 14.1 percent weight loss in 3 months. August - 78 lbs The dietician's progress note dated 5/8/13 recommended adding a medication as an appetite stimulant. A dietary recommendation was signed by the physician on 5/24/13 for an appetite stimulation. The telephone order revealed the Remeron (a medication used as an appetite stimulant) was not ordered until 5/31/13. A physician's order noted on 5/30/13 to increase the Magic cups to two cups with lunch and dinner. A physician's order dated 6/5/13 noted to discontinue the Remeron without a reason documented. The dietician's progress note dated 6/12/13 noted the resident received a magic cup twice a day and Ensure pudding (a nutritionally enhanced pudding) twice a day. The dietician's progress note dated 7/10/13 noted the resident still received a magic cup twice a day. There were a few medications in place, so the pudding was not added to the medication times.	F 325		

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The dietician's progress note dated 7/17/13 noted the resident's diet was changed to pureed with pudding thick liquids.

The dietician's progress note dated 7/19/13 requested a weight recheck. The recheck was comparable to the weight obtained earlier in July. It noted the resident continued on a pureed diet with pudding thick liquids and a magic cup twice daily. It recommended the resident received super cereal (nutritionally enhance oatmeal or cream of wheat) with breakfast.

A physician's order was received on 7/20/13 for super cereal with breakfast for this resident.

The dietician's progress note dated 7/31/13 revealed the resident continued on a pureed diet with pudding thick liquids and a magic cup twice daily.

The dietician's progress note dated 8/13/13 revealed the resident continued on a pureed diet with pudding thick liquids, super cereal, and a plate guard. It was recommended at this time to discontinue the use of the plate guard due to the resident no longer needed it.

Review of May 2013, June 2013, and July 2013 Medication Administration Records (MARs) documented the resident received a magic cup, even though the 5/30/13 physician's order increased the magic cups to 2 cups 2 times a day.

Review on 8/14/13 at 2:45 P.M. of this resident's diet card revealed this resident was supposed to receive a magic cup with lunch and dinner, but failed to note how many magic cups.

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F 325	Continued From page 34 Observation on 8/13/13 at 12:25 P.M. staff served the resident one unopened magic cup. The resident attempted to open the magic cup unsuccessfully. At 12:33 P.M. the staff served orange juice, water, pureed chili, pureed potatoes, pureed broccoli and cheese, and pureed cornbread. Staff assisted the resident to eat. The resident only consumed bites of the meal. Syrup/Honey was not added to the resident's food as planned. Staff did not attempt to offer the magic cup to the resident and the magic cup was left uneaten. Interview on 8/13/13 at 1:45 P.M. direct care staff Q stated this resident could feed himself/herself. He/she said staff should feed this resident if needed. He/she stated staff should give nutritional supplements before attempting other foods. Interview on 8/14/13 at 9:30 A.M. licensed nursing staff J stated this resident required cuing and would sometimes feed himself/herself. Licensed nursing staff were responsible for ensuring the residents consumed their ordered nutritional supplements. Dietary staff were responsible for serving nutritional supplements. Interview on 8/14/13 at 2:30 P.M. direct care staff S stated if a resident should receive a nutritional supplement, it was written on their diet card. Dietary consultant JJ on 8/16/13 at 12:08 P.M. stated he/she followed up on the resident's weight and if a decrease noted he/she would review the telephone orders to see if his/her recommendations were followed. The consultant stated the resident did not always eat and had behaviors at time. He/she also stated the resident liked chocolate would eat that.	F 325		

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F 325	Continued From page 35 The facility policy "House Supplements" updated 11/2009 did not address administration of magic cups. The facility failed to provide nutritional supplements as ordered for this resident with weight loss.	F 325		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This Requirement is not met as evidenced by: The facility identified a census of 33 residents. The sample included 5 residents for medications.	F 329		

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Based on observation, record review and interview, the facility failed to monitor one resident (#70) for black boxed warnings, monitor one resident (#26) for behaviors, monitor the effectiveness of the medication for one resident (#46), and investigate potential causes for one resident's (#31) behaviors.

Findings included:

- The August 2013 Physician's Order Sheet for resident #70 documented a diagnosis of dementia with psychosis (a progressive mental disorder characterized by failing memory and confusion with any major mental disorder characterized by a gross impairment in reality testing)and noted an order for Depakote (a medication used to stabilize mood).

The Significant Change Minimum Data Set 3.0 dated 5/1/13 revealed a Brief Interview for Mental Status score of 1 (less than 7 indicated severely impaired cognition). It documented this resident required limited assistance of one person with eating.

The Care Area Assessment dated 5/3/13 for cognition documented this resident needed staff to help with decisions daily for safety, and to anticipate this resident's needs as he/she only made his/her basic needs known at times.

The care plan dated 4/24/13 for medications with black boxed warnings failed to list Depakote.

Lexi-Comp's Drug Information Handbook for Nursing, 12 th Edition, noted the following Black Box Warning for Depakote: Hepatic (liver) failure resulting in fatalities (deaths) and cases of life-threatening pancreatitis (inflammation of the

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pancrease) have occurred in patients.

Observation on 8/13/13 at 8:15 A.M. the resident sat in a chair. He/she was alert and calm.

Interview on 8/14/13 at 9:30 A.M. licensed nursing staff J stated the nurses were responsible for updating the care plans.

The facility policy "Skilled Nursing Standards of Performance Anti-Psychotic/Psychoactive Utilization Management" undated documented the care plan should "establish approaches for ongoing monitor for side effects of anti-psychotic medications".

The facility failed to monitor for black boxed warnings for Depakote for this resident.

- The August 2013 Physician's Order Sheet for resident #46 documented a diagnosis of hypothyroidism (condition characterized by decreased activity of the thyroid gland). It noted an order for Levothyroxine (a medication used to improve thyroid gland function).

The facility's standing orders noted staff should obtain a thyroid stimulating hormone (TSH) level on a resident who received Levothyroxine.

The Quarterly Minimum Data Set 3.0 dated 5/26/13 revealed a Brief Interview for Mental Status score of 4 (less than 7 indicated severely impaired cognition).

The Care Area Assessment dated 2/26/13 for cognition revealed this resident had cognitive and memory deficits. He/she was alert and oriented times 1 with poor recall. Staff should provide reorientation, and verbal cues and reminders with

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Activities of Daily Living. Staff should encourage him/her to group activities for increased mental stimulus.

Lab results reported since admission on 2/14/13 failed to document a TSH level.

Observation on 8/12/13 at 2:45 P.M. the resident participated in nail care. He/she appeared alert and calm, and conversed with staff appropriately.

Interview on 8/14/13 at 9:30 A.M. licensed nursing staff J said when staff admitted a resident, the admitting nurse should write all applicable standing orders on a telephone order form.

The facility failed to provide a policy about medication monitoring.

The facility failed to monitor for the effectiveness of the Levothyroxine for this resident.

- Resident #31's quarterly Minimum Data Set 3.0 Assessment (MDS) dated 6-19-13 documented the resident's Brief Interview for Mental Status Score of 12, which indicated the resident had moderately impaired cognition. The MDS documented the resident displayed verbal behaviors 1 to 3 days of the seven day assessment period and rejected care 1 to 3 days of seven day assessment period.

The Psychotropic Care Area Assessment (CAA) dated 9-28-12 documented the resident received medications prescribed by his/her physician and psychiatrist, had periods of anxiety with inappropriate verbalization, panic attacks, and swore at staff and other residents.

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The 8-9-13 Care Plan documented the resident received anti-psychotic medication and had an increase in Buspar (an anti-depressant medication) dosage. The resident was impulsive, became angry, anxious and was verbally abusive at times. The resident required cueing, reassurance, and reality orientation at times. The care plan directed staff to speak to the resident in a calm, quiet manner as the resident's behavior escalated easily. The care plan documented the resident was obsessed with his/her inhalers and oxygen. The care plan directed staff to remind the resident to call for assistance if he/she became anxious or had shortness of air.

Review of the resident's medications revealed he/she received alprazolam (an anti-anxiety medication) 0.25 milligrams (mg) three times daily and as needed for anxiety, Seroquel (an anti-psychotic medication) 25 mg twice daily and 50 mg at bedtime and buspirone (an antidepressant) 10 mg three times daily.

The 7-12-13 Psychiatric exam documented the resident with some improvement of the resident's behaviors.

The 5-29-13 interdisciplinary note (ID) with no time written documented the resident came to the nurses' station multiple times during the day and requested his/her inhaler and the resident had memory problems. Staff informed the resident's family if the resident continued to have the psychotic behaviors, he/she would be referred to a gerontology (elderly) psychiatric unit.

The 5-31-13 ID note with no time written documented the resident's family requested staff to inform them when the resident had temper

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tantrums. The physician prescribed Seroquel for the resident.

An undated and untimed ID note entered between 7-27-13 and 7-31-13 documented the resident continued to receive Buspar and Seroquel, became disruptive at times, screamed, yelled and asked for his/her inhalers. The resident was hateful and inappropriate toward staff.

On 8-7-13 with no time written, the ID note documented staff notified the resident's family of the resident's belligerent and disruptive behaviors. The resident demanded his/her inhalers and breathing treatments. Staff gave the resident the prescribed treatments but the resident did not get relief. The ID note documented the resident had anxiety and his/her verbal aggression escalated.

On 8-9-13 at 5:35 P.M. the ID note documented staff obtained an order to increase the resident's Buspar dosage for his/her increased behaviors.

The resident's record lacked evidence staff thoroughly investigated causes of the resident's behavior or provided individualized interventions when the resident displayed behaviors prior to receiving Seroquel.

Observation on 8-12-13 at 4:34 P.M. revealed the resident sat in his/her wheelchair in the activity room with other residents and staff and no behaviors exhibited.

Observation on 8-13-13 at 8:30 A.M. revealed the resident in the dining room for the breakfast meal with other residents and staff and no behaviors exhibited.

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BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

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F 329	Continued From page 41 On 8-13-13 at 4:08 P.M. direct care staff U stated the resident had behaviors when he/she had difficulty with breathing and the resident would yell and curse staff. Direct care staff U stated when the resident had behaviors, staff left and came back later. On 8-14-13 at 10:14 A.M. direct care staff Q stated the resident did not like 2 people entering his/her room, had a lot of behaviors and would apologize after displaying behaviors. Direct care staff Q stated the resident became anxious because he/she thought something was wrong. He/she stated the resident screamed throughout his/her showers. On 8-14-13 at 11:41 A.M. social services staff HH stated staff redirected the resident, spoke to the resident in a calm manner, provided one to one interaction, and redirected the resident. He/she acknowledged the care plan lacked the specific behaviors and interventions for the behaviors displayed. On 8-14-13 at 1:17 P.M. licensed staff J stated he/she was not certain what triggered the resident's behaviors and when the resident had a panic attack, the resident felt staff did not respond fast enough. He/she stated staff tried to re-direct the resident, did not argue with the resident and gave the resident what he/she wanted without conversation because that also upset the resident. The facility failed to investigate and provide ongoing non-pharmacological interventions for the resident's behaviors prior to and after receiving Seroquel.	F 329		

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F 329	Continued From page 42 - The unsigned Physician's Order Sheet (POS) dated 8/3/13 for resident #26 revealed a diagnoses of delirium (sudden severe confusion, disorientation and restlessness) and anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The quarterly Minimum Data Set 3.0 dated 6/20/13 revealed a Brief Interview for Mental Status score of 9 (moderately impaired cognition). The revised care plan dated 6/26/13 for memory, mood, cognition, and delirium revealed the resident received Depakote Sprinkles (an anti-seizure medication used for behaviors) for mood disorder. Depakote levels would be obtained monthly and as needed, and reported to the physician. The revised care plan dated 5/29/13 for antipsychotic medication revealed the pharmacist would review the resident's medications monthly and as needed. Nursing staff would report side effects and report mood and behavior changes to the physician/psychiatrist, and nursing staff would obtain Depakote labs and monitor for toxicity. The Abnormal Involuntary Movement Scale (AIMS) dated 5/9/12 revealed the resident did not have any abnormal involuntary movement. The unsigned POS dated 8/3/13 revealed orders for Depakote 125 milligrams (mg) by mouth (PO) 2 capsules at bedtime and 125 mg PO every morning for delirium/anxiety. Record review on 8/13/13 at 2:15 P.M. lacked documentation of a Behavioral Monitoring form for June 2013 for Depakote used for delirium/anxiety.	F 329		

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F 329	Continued From page 43 The Behavior Monitoring form for July 2013 revealed documentation gaps from 7/1/13 to (-) 7/23/13 on the night/day shifts. Anxiety was listed as a behavior and lacked documentation of what the resident's signs of anxiety were. The Behavioral Monitoring form did not identify what behavioral medication the resident received and was monitored. The Behavioral Monitoring form for August 2013 did not identify what behavioral medication was used and monitored. There were 7 days of 13 days that lacked documentation of behaviors. Observation on 8/12/13 at 3:00 P.M. revealed the resident sat quietly in a wheelchair while her/his finger nails were polished. Interview on 8/13/13 at 2:30 P.M. with licensed nursing staff M stated nursing staff documented on the Behavioral Monitoring form daily when Depakote was used for behaviors, and the behavioral medication used should be identified on the Behavioral Monitoring form. Interview on 8/13/13 at 4:32 P.M. with licensed nursing staff H stated nursing staff documented on the Behavioral Monitoring form the effects of Depakote when used for behaviors. Interview on 8/14/13 at 3:00 P.M. with administrative nursing staff D stated nursing staff should document behavioral daily on the Behavioral Monitoring form when Depakote was used for behaviors. The facility failed to monitor behavioral medications for this resident.	F 329		
F 371	483.35(i) FOOD PROCURE,	F 371		

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F 371 SS=F	Continued From page 44 STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: The facility reported a census of 33 residents. Based on observation, interview, and record review, the facility failed to maintain clean dietary bussing carts for the long term care kitchenette for 1 of 1 days on survey, failed to maintain hair restraints in the main kitchen food service area, and failed to change gloves between procedures in the main kitchen. Findings included: - Observation on 8/13/13 at 11:15 A.M. revealed three male dietary staff with facial hair uncovered. Two male dietary staff wore clean ball caps that did not restrain all the hair. Hair nets were not worn under the ball caps. Observation on 8/13/13 at 11:45 A.M. revealed dietary staff EE wiped sweat off her/his face on her/his 3/4 length shirt sleeves and touched the left side pocket of the upper left sleeve to store a digital thermometer. Dietary staff EE did not remove her/his gloves after touching the left sleeve. Dietary staff EE pushed the kitchen door with the same gloves and removed the digital thermometer from the left sleeve pocket and	F 371		

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F 371	Continued From page 45	F 371		

tempted salads. Dietary staff EE touched an individual salad bowl while wearing the same gloves. Dietary staff EE then returned to the main kitchen and removed gloves and washed her/his hands

Interview on 8/14/13 at 10:50 A.M. dietary staff DD stated she/he was not sure what the policy and procedure was regarding hair and beard nets and dietary staff EE stated staff should remove her/his gloves after touching her/his sleeve.

Interview on 8/14/13 at 4:00 P.M. dietary staff FF stated dietary staff with facial hair 1/4 to 1/2 inch in length did not have to wear a beard net, and the previous administrator informed her/him the ball caps were okay to wear in the kitchen area.

The updated policy and procedure titled Personal Hygiene dated 10/2008 revealed dietary staff would wear a clean hat or other hair restraint in the kitchen. Hair must be appropriately restrained or completely covered. Beards or any body hair exposed must be covered. Hands must always be washed prior to beginning work and after handling any unsanitary items. Clothing must be clean and sanitary precautions must be followed to prevent cross contamination.

Observation on 8/13/13 at 12:15 P.M. revealed two long term care bussing carts were dirty with crumbs, food debris, and liquid stains.

Interview on 8/14/13 at 10:50 A.M. with dietary staff DD stated staff should clean the food carts. The dietary staff have a daily cleaning scheduled.

The Health Care Daily Cleaning Duties dated 8/12/13 and 8/13/13 revealed the staff should clean the bussing carts every day.

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F 371	Continued From page 46 The facility failed to prepare, distribute and serve food under sanitary conditions.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This Requirement is not met as evidenced by: The facility identified a census of 33 residents. The sample included 5 residents for medications. Based on observation, record review and interview, the facility's consultant failed to recognize the need to monitor one resident (#70) for black boxed warnings, monitor one resident (#26) for behaviors, and monitor the effectiveness of the medication for one resident (#46). Findings included: - The August 2013 Physician's Order Sheet (POS) for resident #70 documented a diagnosis of dementia with psychosis (a progressive mental disorder characterized by failing memory and confusion with any major mental disorder characterized by a gross impairment in reality testing) and noted an order for Depakote (a medication used to stabilize mood). The Significant Change Minimum Data Set 3.0	F 428		

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F 428	Continued From page 47 dated 5/1/13 revealed a Brief Interview for Mental Status score of 1 (less than 7 indicated severely impaired cognition). It documented this resident required limited assistance of one person with eating. The Care Area Assessment dated 5/3/13 for cognition documented this resident required staff to help with decisions daily for safety, and to anticipate this resident's needs as he/she only made his/her basic needs known at times. The care plan dated 4/24/13 for medications with black boxed warnings failed to list Depakote. Lexi-Comp's Drug Information Handbook for Nursing, 12 th Edition, noted the following Black Box Warning for Depakote: Hepatic (liver) failure resulting in fatalities (deaths) and cases of life-threatening pancreatitis (inflammation of the pancrease) have occurred in patients. Review of the Drug Regimen Reviews dated 5/10/13, 6/25/13, and 7/16/13 failed to address the need to monitor this resident for the black boxed warnings for Depakote. Observation on 8/13/13 at 8:15 A.M. the resident sat in a chair. He/she appeared alert and calm. Interview on 8/14/13 at 9:30 A.M. licensed nursing staff J stated the nurses were responsible for updating the care plans. Interview on 8/14/13 at 3:10 P.M. pharmacy consultant AA stated he/she would alert nursing staff when the resident was on a medication with a black boxed warning to ensure the black boxed warnings were on the POS, Medication Administration Records, and the care plans.	F 428		

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The facility policy "Skilled Nursing Standards of Performance Anti-Psychotic/Psychoactive Utilization Management" undated documented the care plan should "establish approaches for ongoing monitor for side effects of anti-psychotic medications".

The facility's consultant failed to recognize the need to monitor for black boxed warnings for Depakote for this resident.

- The August 2013 Physician's Order Sheet for resident #46 documented a diagnosis of hypothyroidism (condition characterized by decreased activity of the thyroid gland). It noted an order for Levothyroxine (a medication used to improve thyroid gland function).

The facility's standing orders noted staff should obtain a thyroid stimulating hormone (TSH) level on a resident who received Levothyroxine.

The Quarterly Minimum Data Set 3.0 dated 5/26/13 revealed a Brief Interview for Mental Status score of 4 (less than 7 indicated severely impaired cognition).

The Care Area Assessment dated 2/26/13 for cognition revealed this resident had cognitive and memory deficits. He/she was alert and oriented times 1 with poor recall. Staff should provide reorientation, and verbal cues and reminders with Activities of Daily Living. Staff should encourage him/her to group activities for increased mental stimulus.

Lab results reported since admission on 2/14/13 failed to document a TSH level.

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Review of the Drug Regimen Reviews dated 3/19/13, 4/16/13, 5/10/13, 6/25/13, and 7/16/13 failed to address the need to obtain a TSH level.

Observation on 8/12/13 at 2:45 P.M. the resident participated in nail care. He/she was alert and calm, and conversed with staff appropriately.

Interview on 8/14/13 at 9:30 A.M. licensed nursing staff J said when staff admitted a resident, the admitting nurse should write all applicable standing orders on a telephone order form.

Interview on 8/14/13 at 3:10 P.M. pharmacy consultant AA stated he/she reviewed lab results with each visit.

The facility failed to provide a policy about medication monitoring.

The facility's pharmacy consultant failed to monitor for the effectiveness of the Levothyroxine for this resident.

- The unsigned Physician's Order Sheet (POS) dated 8/3/13 for resident #26 revealed a diagnoses of delirium (sudden severe confusion, disorientation and restlessness) and anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The quarterly Minimum Data Set 3.0 dated 6/20/13 revealed a Brief Interview for Mental Status score of 9 (moderately impaired cognition).

The revised care plan dated 6/26/13 for memory, mood, cognition, and delirium revealed the resident received Depakote Sprinkles (an anti-seizure medication used for behaviors) for

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mood disorder. Depakote levels would be obtained monthly and as needed, and reported to the physician.

The revised care plan dated 5/29/13 for antipsychotic medication revealed the pharmacist would review the resident's medications monthly and as needed. Nursing staff would report side effects and report mood and behavior changes to the physician/psychiatrist, and nursing staff would obtain Depakote labs and monitor for toxicity.

The Abnormal Involuntary Movement Scale (AIMS) dated 5/9/12 revealed the resident did not have any abnormal involuntary movements.

The unsigned POS dated 8/3/13 revealed orders for Depakote 125 milligrams (mg) by mouth (PO) 2 capsules at bedtime and 125 mg PO every morning for delirium/anxiety.

Record review on 8/13/13 at 2:15 P.M. lacked documentation of a Behavioral Monitoring form for June 2013 for Depakote used for delirium/anxiety.

The Behavior Monitoring form for July 2013 revealed documentation gaps from 7/1/13 to (-) 7/23/13 on the night/day shifts. Anxiety was listed as a behavior and lacked documentation of what the resident's signs of anxiety were. The Behavioral Monitoring form did not identify what behavioral medication the resident received and was monitored for.

The Behavioral Monitoring form for August 2013 did not identify what behavioral medication was used and monitored. There were 7 days of 13 days that lacked documentation of behaviors.

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F 428	Continued From page 51 The Medication Regimen Review dated 1/14/13, 2/11/13, 3/19/13, 4/16/13, 5/10/13, 6/25/13, and 7/16/13 revealed no irregularities. Observation on 8/12/13 at 3:00 P.M. revealed the resident sat quietly in a wheelchair while her/his finger nails were polished. Interview on 8/13/13 at 2:30 P.M. with licensed nursing staff M stated nursing staff documented on the Behavioral Monitoring form daily when Depakote was used for behaviors, and the behavioral medication used should be identified on the Behavioral Monitoring form. Interview on 8/13/13 at 4:32 P.M. with licensed nursing staff H stated nursing staff documented on the Behavioral Monitoring form the effects of Depakote when used for behaviors. Interview on 8/14/13 at 3:00 P.M. with administrative nursing staff D stated nursing staff should document behavioral daily on the Behavioral Monitoring form when Depakote was used for behaviors. The pharmacy consultant staff AA reviewed the Behavior Monitoring forms. Interview 8/14/13 at 3:10 P.M. with pharmacy consultant staff AA stated resident's medical records were reviewed monthly and she/he would inform the nursing staff of incomplete Behavioral Monitoring forms. The facility Pharmacy Consultant AA failed to identify and report the lack of monitoring of this resident's behavioral medications.	F 428		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		

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F 520	Continued From page 52 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This Requirement is not met as evidenced by: The facility identified a census of 33 residents with 18 included in the sample. Based on observation, record review, and staff interview the facility failed to have a Quality Assessment and Assurance (QAA) Committee that identified issues that required plans of action. Findings include: - During an interview on 8/14/13 at approximately 5:15 P.M. Administrative Nursing Staff D reported the facility had a QAA committee that met monthly. The information from the QAA meeting was presented at the July staff meeting, and staff	F 520		

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F 520	Continued From page 53	F 520		

were educated on the QAA committee. Administrative Nursing staff D had identified the nursing department needed a total revamp to keep the residents safe.

The facility failed to ensure the QAA committee addressed Liability notices. Please see F156 for additional information.

The facility failed to ensure the QAA committee addressed the residents' right to exam the survey results. Please see F167 for additional information.

The facility failed to ensure the QAA committee addressed the residents right to choose activities, schedules, and health care consistent with his or her interests. Please see F242 for additional information.

The facility failed to ensure the QAA committee addressed development of comprehensive care plans. Please see F279 for additional information.

The facility failed to ensure the QAA committee addressed the revision of care plans. Please see F280 for additional information.

The facility failed to ensure the QAA committee addressed quality of care. Please see F309 for additional information.

The facility failed to ensure the QAA committee addressed services for accidents hazards, and prevention of falls. Please see F323 for additional information.

The facility failed to ensure the QAA committee addressed nutrition. Please see F325 for

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F 520	Continued From page 54 additional information. The facility failed to ensure the QAA committee addressed unnecessary drugs. Please see F329 for additional information. The facility failed to ensure the QAA committee addressed storing, preparing, and serving food under sanitary conditions. Please see F371 for additional information. The facility failed to ensure the QAA committee addressed pharmacy services. Please see F428 for additional information The facility failed to ensure the QAA committee addressed water temperatures. Please see K.A.R. 26-40-305(e)(4). The facility failed to have an effective Quality assurance program in place to monitor and implement corrective actions for issues identified.	F 520		